



## **Blue Cross Blue Shield of Michigan's Concerns Regarding Senate Bills 895-898**

**Issue #1: Schools that pool for health coverage under this legislation should be regulated like Multiple Employer Welfare Arrangements (MEWAs).**

***Rationale:** MEWAs have a long history marred by financial instability and even fraud. Due to licensing requirements that are often less stringent than those imposed on traditional insurers, MEWAs are at far greater risk of becoming insolvent when claims suddenly or unexpectedly exceed their ability to pay them. To help address this issue in Michigan, the current law was put into place to allow school districts to join together in pools to self-insure for health coverage only with the oversight of the Insurance Commissioner and the consumer protections found in Michigan's MEWA statute. This structure was put in place to help mitigate many of the unintended consequences of MEWAs – namely insolvency ramifications faced by consumers.*

*MEWAs have long been unstable in the marketplace and eliminating State insurance regulations of MEWAs will only perpetuate their volatility and instability in Michigan. Specific insurance regulations that will be eliminated for schools that pool for health coverage absent of insurance oversight will be:*

- *Solvency requirements*
- *Notice to insured consumers regarding liability and claims*
- *Open access to books and records by the Insurance Commissioner*
- *A MEWA security fund to help pay the claims of an insolvent MEWA*

*Opening up this lack of regulation to school districts sets a dangerous precedent for other groups wishing to form a MEWA with no regulatory oversight.*

**Issue #2: Information regarding provider/hospital fees should not be disclosed.**

***Rationale:** Health carriers negotiate specific rates and fees for different provider groups and hospitals. This negotiation process is based on a number of different factors (i.e. geography, size, etc.). If negotiated rates were publicly reported annually, this could hinder the negotiating and contracting process between provider groups/hospitals and insurers because certain provider groups would likely seek higher fees. For example, a rural hospital could demand higher Diagnosis Related Group (DRG) rates comparable to that of urban hospitals even though geographical, size, Graduate Medical Education (GME) funding differences, etc. warrant lower rates. Ultimately, this would have a negative impact on the contracting process between employers and health carriers. The*

*network and provider contracting process is very intricate as health care carriers work to ensure the best quality and access to care for consumers/employers in the most cost conscientious way possible. A release of proprietary contracting data would diminish this process and hurt consumers/employers who would likely see an increase in health care costs as a result of this unstable contracting process.*

**Issue #3: Health care carriers should be able to report claims experience data based on how they actually rate and pool school districts rather than strictly on an individual district basis.**

**Rationale:** *For health care carriers, an industry rated customer (a component of community rating) is generally a group customer with less than 100 enrolled contracts with its primary industry classification falling within an industry rating pool defined by the carrier; education is an industry that does fall under this classification. Therefore, the education industry's rates are based upon the collective experience for all customers with less than 100 enrolled contracts within the industry.*

*Group customers that consist of more than 100 contracts may have claims experience data made available to them because this is how their rates are determined. Self-insured groups also have that data available to them because of the sheer nature of the "self-insuring process."*

*Rating is a uniform process that health carriers use across the board for their various rated groups. To ask that claims experience data be made available to school districts on an individual level when this is not done with other industries could prove to be administratively burdensome and could lead to increased health care costs for consumers. This also sets a dangerous precedent that could permanently alter the longstanding and effective process of industry/community rating.*

*Additionally, providing claims experience data on a level that is not consistent with the actual rating process also opens Michigan up to "gaming" in the health care system as a whole. Gaming could occur when a seemingly healthy small group leaves a larger pool based on a relatively good year of experience data (thus assuming good health and low rates continuing) and sees rates increase the following year because of an adverse health event in the small group. Consequently, that group could return to the larger pool thereby "gaming" the system. This is an unstable and costly practice to the health care system as a whole.*